GOVERNMENT AS REGULATOR*

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IT will come as no surprise to you that the prevailing philosophy in Washington is to rely on the free market as much as possible, whether in health care or in practically any other industry. Consequently, it is natural that the increasing role of profit-making enterprise in health care—the entrepreneur—is looked upon with some favor.

It is also true that this administration's free market philosophy has led to some differences about health care policy with prior administrations. For example, leaving aside the now very faint debate over national health insurance, this administration has opposed the hospital cost control initiatives of the Carter administration, further funding of local health planning agencies, and federal subsidies for developing Health Maintenance Organizations. In each case, these prior policies were dropped in favor of greater reliance on the private market.

It would be incorrect, however, to assume a major change in the federal perspective toward encouraging competition among health care professionals. For example, one of the most significant federal efforts to inject competition into the health care market was the Federal Trade Commission's antitrust case against the American Medical Association.† Initiated in 1975 in the Ford administration, the case was decided in 1979 during the Carter administration, and has been supported strongly during this administration. This case is a symbol of the proposition that basic principles of free competition, including the rules against competitors agreeing not to advertise, to set fees, or to prohibit certain organizational forms of selling services, should apply to physicians as well as everyone else.

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†American Medical Ass'n, 94 F.T.C. 701 (1979), *aff'd as modified*, 638 F.2d 443 (2d Cir. 1980), *aff'd by an equally divided court*, 455 U.S. 676 (1982).

The Federal Trade Commission and the American Medical Association have recently emerged from, at least initially, a bruising battle in the Congress over whether the FTC should retain the authority to police antitrust violations and deceptive practices by all professionals, including physicians and dentists. To the great credit of the AMA, it has been willing to support a compromise under which the FTC would retain authority over aspects of professional activity pertaining to competition and commercial activity, while the FTC would not be involved in legal challenges to legitimate state laws that specify permissible tasks and duties for professionals and education and training standards. Moreover, the sweeping restrictions on advertising, corporate practice, and pricing that once appeared in medical associations' codes of ethics have largely been abandoned. All these signs point to increasing acceptance of the rules of free competition among health care professionals and a rejection of the idea that vigorous competition is unethical or fundamentally harmful to the integrity of the profession or its ability to serve the public.

On the other hand, figuring out the governmental role toward profit-making entities in health care is far more complex than simply saying let the free market work. Government is involved so intimately and in so many ways with the health care system that its policies along a whole series of fronts affect the type and scope of the role of health care entrepreneurs. Once we drop the relatively straightforward proposition that physicians and dentists should compete on price and be allowed to advertise, questions about entrepreneurialism become a good deal more complicated. As I shall discuss further below, the fundamental structural problem in the economics of health care—achieving high quality care at the lowest possible cost when the standard market incentives for achieving economic efficiency are absent or distorted—is not necessarily any less troublesome with either entrepreneurial or traditional health care providers.

The Government's Preoccupation with Costs

Let us review the various roles of government regarding health care entrepreneurs and the health care industry in general. Government, at the federal or state level, pays for services for low-income persons, the elderly and certain other groups; pays for research and teaching; regulates who can provide services through licensing, quality control, certificate of need requirements, etc.; promotes competition; taxes (or refrains from taxing) health care providers and organizations; and determines reimbursement rates for pub-

licly financed care and sometimes sets premium levels for private insurance.

Government policies in each of these areas have a major impact on the role for-profit enterprises will play in the health care industry as well as on the entire industry. A major reason that many argue for increased roles for competition and the private market in health care is that first governmental function—paying for health care services for some groups in our society. I think it is fair to say that the desire to control costs is the single strongest force on government policies in health care and will remain so for some time to come. Government is also concerned, of course, with insuring access to health care services for everyone regardless of income as well as insuring some minimal quality standards, but the preoccupation with costs arises because we have assumed certain social obligations regarding access and quality and it is increasingly difficult to come up with the money to meet those obligations.

Arguments why the profit motive and, more generally, free market competition in health care will lower costs and improve access are familiar: The profit motive will spur efforts by health care providers to become more efficient by lowering (or at least slowing the growth of) costs and by seeking more efficient ways to provide services. New forms of organization will be encouraged to take advantage of profitable opportunities. Health care business enterprises can attract private capital. Economies of scale, for example, through multifacility chains, can lead to cost reductions. And health care entrepreneurs will improve access for some groups by exploiting profitable opportunities where service is absent or inadequate. As is typically the case with complex social developments, achieving these goals is not as simple as it sounds, and a number of possible problems are raised along the way.

Efficiency

First, even though economic theory suggests that profit-making entities *should* be more efficient, in fact, data about efficiency are mixed. Some empirical information suggests that the lengths of for-profit hospital stays and the personnel per patient in for-profit hospitals are lower than for nonprofit hospitals, but it is not clear whether these differences are due to efficiency or the reduced needs of a different patient population. Some evidence even suggests that costs of profit-making hospitals are *higher,* and that the greater net revenues of these hospitals stem from higher margins on some types of services, particularly laboratory and other ancillary services. On the whole, however, the potential for efficiency is still promising, not only for the profit-

making institutions themselves, but for spurring nonprofit, more traditional institutions to become more efficient to compete, if not for profits, then for patients.

Selective Provision of Service

Profit-making entities will concentrate on serving the most profitable sector of the population, and, unless required to do so, will rarely provide any service for which they are not directly compensated. This behavior of profit-making entities is perfectly understandable and will not change, absent regulatory requirements. Government must simply take this into account in deciding how to pay for medical care for low income people, for graduate medical education, and for other services provided the community by nonprofit institutions and in determining whether to require for-profit institutions to provide services they lack a financial incentive to offer.

This very central problem arises most prominently, of course, in the case of for-profit hospitals that avoid serving low income people, outpatient or inpatient. There is no single—and certainly no simple—solution to this very difficult issue. At least, government should get a better, more explicit understanding of who is subsidizing what for how much. We could think of a whole series of subsidies that have grown up more or less piecemeal over time, including third party payers subsidizing graduate education, private insurance plans subsidizing Medicare, taxpayers subsidizing institutions that do not pay taxes, and so on. It would be helpful for public decision-making to understand better how these subsidies work and, over the long run, to rationalize them to some extent. Further, it seems clear that the public will have to pay more for graduate education and services to low income people as subsidies from high-profit patients or services are lost when these patients are attracted to institutions that do not assume these responsibilities. Finally, we should not rule out requiring that for-profit institutions provide services that they have no financial incentive to provide if it makes sense from a societal point of view.

Creating Harmful Incentives

There is an argument that increasing the role of the profit motive in health care can create perverse and harmful incentives, for example, by encouraging physicians to order more laboratory services from a profit-making laboratory owned by the physicians themselves or, more generally, by offering unnecessary services of all types because of the profit motive.

This argument is cause for concern and the potential for abuse is significant enough to warrant selective and periodic review of the ordering of services by private third party payers, Medicare and Medicaid agencies. Further, it may be appropriate in some situations to insure that the patient has some choice in obtaining ancillary services to achieve the benefits of competition. For example, the Federal Trade Commission Eyeglasses Rule guarantees that consumers can have a copy of a prescription for eyeglasses so that they can shop around when they purchase the eyeglasses themselves. But the potential for ordering unnecessary services has always been present, and the increasing role of profit-making entities at most represents a quantitative, but not a qualitative, change in the nature of this problem.

Breaking Down Ethical Standards

Another argument is that profit-making behavior in the health care industry will promote a breakdown in ethical standards, encourage shoddy services, and lead to a lessening of social concern and altruistic behavior by physicians and other health professionals. One disturbing study of nursing homes showed that the level of satisfaction expressed by families of residents of nonprofit nursing homes was substantially higher than families of residents in proprietary homes, perhaps because of the simple possibility that employees of nonprofit homes care more about their patients. The traditional strong objection to advertising, not only among physicians, but among other professional groups, has certainly been motivated to some extent by these general concerns.

The difficulty in giving weight to these arguments has been that—to the extent these harmful results occurred, and they are very hard to measure—the remedy of flat prohibitions on advertising or other commercial behavior, e.g., use of trade names, salaried physicians, and corporate forms of organization, is too sweeping. Banning *all* advertising means banning truthful, nondeceptive advertising as well as deceptive advertising. Discouraging multifacility chains by prohibiting trade names means preventing high quality, efficient chains from thriving in addition to stopping any theoretical undesirable behavior by chains. As a result, the federal government, at least, has justifiably frowned on such broad prohibitions and where they remain they are likely to be challenged, either through antitrust litigation, proposals for legislative change at the state level, or political pressure from groups adversely affected. Further, commercial restrictions, e.g., restrictions on location, justified in the name of promoting quality, will surely come under

increasing scrutiny unless the restriction can be shown to be linked to quality on a documented, substantive basis, rather than mere speculation.

Efficient Organization of Health Care Delivery

Finally, let me mention a problem with entrepreneurs in health care that, in the long run, is likely to be the most important. The great dilemma in promoting a healthy population at reasonable cost is to reduce the amount of our health resources committed to the resource-intensive end of the health care spectrum—inpatient care, specialty services, and complex interventions in the late stage of disease—and to increase the commitment to the low-resource end of the spectrum—outpatient care, self-care, and prevention. The two great components of the solution to this problem are promoting healthful behavior in the population and encouraging the growth of health care organizations with structural incentives to care for people in low-cost, effective ways.

Profit-making entities will have the incentive to find opportunities to provide care whenever the projected rate of return makes the opportunity a good investment. This tendency is both an advantage and disadvantage of entrepreneurial behavior, depending on the circumstances. The incentive for the entrepreneur to fill in a gap in the system where no need is being met is surely an advantage. For example, free-standing emergency care centers may provide access to many consumers who have nowhere to turn or who are overloading high cost hospital emergency rooms. On the other hand, a disadvantage of profit-making entrepreneurs is that the profit motive alone has no inherent connection with the need to treat the total health needs of individuals in effective low-cost ways. The profit motive means only that wherever a service or package of services can be delivered at a profit, the entrepreneur will have the incentive to reduce costs and maximize profits for those services. Consequently, if the market offers profitable opportunities to provide services but in ways that raise overall social costs, the entrepreneur will plunge ahead unless someone stops him or changes his incentives.

In Paul Starr's excellent book, *The Social Transformation of American Medicine,* he tells of a Congressional debate over the terms of reimbursement of kidney dialysis services, in particular, the extent to which home dialysis should be encouraged rather than institutional dialysis. One of the major profit-making companies that provides institutional dialysis helped lobby in the Congress to maintain more permissive reimbursement standards for

institutional dialysis. Now, assume, for purposes of discussion, that home dialysis is often cheaper and more effective and that we should encourage that form of treatment. As long as profit-making opportunities for institutional dialysis exist, the entrepreneur is likely to take advantage of them. The entrepreneur will minimize its own costs for this service, but efficient delivery of institutional dialysis may not be terribly helpful if institutional dialysis itself tends to be inherently inefficient from a social point of view.

The underlying cause of this dilemma is that third party reimbursement, either public or private, along with the patient's frequent inability to make decisions about what to "buy," encourages inefficient use of resources. The most likely solution to this organizational dilemma is to tie the financial incentives of minimizing the total costs of health care for the individual to greater influence over the organization and delivery of care. This has been, of course, the principal rationale for health maintenance organizations.

How can we take advantage of the benefits that the private market and the entrepreneur have to offer without falling into the trap of further fragmenting our health care system? We have to look for ways to design financing mechanisms that link the profit motive to efficient organization of health care systems. For example, preferred provider organizations give profit-making entities the opportunity to contract with a number of providers for service on a regular basis and on more or less fixed terms, while retaining some influence over the overall costs of delivery of service. Such organizations also retain the traditional fee for service system and freedom of patients to go to providers outside the system. Profit making health maintenance organizations, which combine the financing and organization of care on a more structured basis, also continue to grow. Of 280 such organizations in operation in 1983, 56 were owned by for-profit companies, an increase of at least a third over 1981.* The administration has proposed experimenting with Medicare "vouchers" whereby a Medicare enrollee could contract with a private plan to provide Medicare services and pocket the difference if the plan's fee is lower than the value of the voucher.

To the extent that the profit motive and more traditionally commercial ways of offering services lead health care providers to organize in ways that minimize overall health costs, the American health care system will move toward becoming more effective and efficient. However, to the extent that entrepreneurs simply exploit high-profit segments of the market in a way that

*Private sector moves in as Washington ends its financial assistance for HMOs. *National Journal*, September 3, p. 1788, 1983.

perpetuates a fragmented, high-cost way of caring for the population, they will, as Paul Starr says, simply "reproduce the defects of the traditional system on a grander scale."

CONCLUSION

In many areas of the health care system, particularly the delivery of physicians', dentists', and other professional services, the federal government's perspective is that the traditional rules of free competition should apply. Because of the overriding importance of third-party reimbursement, and particularly the costs of the major public programs, Medicare and Medicaid, we can expect continued efforts to tailor reimbursement policies to minimize costs, to encourage at least middle and upper income consumers to consider costs in using services, and to provide incentives to health care professionals for efficient delivery of these services.

In the case of hospitals and more complex health care institutions, the organization of service becomes increasingly important, and relying on the "free market" will take us only so far in achieving our principal objectives for our health care system. Consequently, government will have to be creative—and careful—in choosing policies, particularly reimbursement policies, that allow us to achieve the advantages of entrepreneurial incentives, but which prevent entrepreneurialism from simply exacerbating the problems of our high quality, but high cost and inefficiently organized, health care system.